WHAT IS CLAIMED IS:

1. A documentation system comprising

a preprinted form having a plurality of recording sections wherein each one of said plurality of recording sections is assigned as a discrete recording section for a designated condition in a selected printed format for recording information relating to its associated designated condition;

a recording person for recording on the preprinted format and in the appropriate discrete recording section one of a predetermined encoded indicia representing information developed for a designated condition;

an input member used by said recording person for recording information specific to the designated condition communicated to said recording person by a first person, said information being recorded by said recording person in the form of encoded indicia in at least one discrete recording section of said recording member;

a transcriber which is responsive to the preprinted format containing the encoded indicia for providing at least one report section template corresponding to the discrete recording section for its associated designated condition, said report section comprising optional text variable segments each of which are assigned to one of said predetermined encoded indicia, said transcriber being responsive to said encoded indicia recorded in

said at least one discrete report section to decode the optional text variable segment assigned to one of the predetermined encoded indicia; and

a report prepared by the transcriber which is specific to each designated condition comprising optional text variable segments documenting the designated condition.

2. A medical documentation system comprising

apparatus for recording information relating to at least one of a designated patient's current medical condition, a physical examination, a diagnosis and a treatment plan;

an input device operative with said apparatus for recording medical information communicated by a first person to a second person during a physical examination of the designated patient, said information being recorded by said first person on the apparatus in the form of predetermined encoded indicia; and

a processor having at least one report section template corresponding to one of a patient's current medical condition, a patient's physical examination, a patient's diagnosis and a patient's treatment plan, said at least one report section template comprising optional text variable segments each of which are assigned to a selected one of said predetermined encoded indicia, said processor being operative to decode each of said one of the predetermined encoded indicia into its assigned optional text variable segment in said at least one discrete recording section and storing the same in a retrievable format.

3. The medical documentation system of claim 2 further comprising

an imaging member responsive to the processor for preparing a patient's report specific to the designated patient's at least one of a medical condition, physical examination, diagnosis and treatment plan comprising the optional text variable segments stored in said retrievable format.

4. The medical documentation system of Claim 3 wherein said processor includes

a computer for the decoding each one of said predetermined encoded indicia into its corresponding optional text variable segment.

5. The medical history documentation system of Claim 4 wherein said computer further comprises

a comparator for comparing the optional text variable segment to the encoded indicia recorded on the recording member.

6. The medical history documentation system of Claim 5 wherein said computer verifies the results of the comparison of the optional text variable segments with the encoded indicia.

7. A medical documentation system comprising

a recording member having a plurality of recording sections formed thereon for recording information relating to at least one of a designated patient's current medical condition, a physical examination, a diagnosis and a treatment plan;

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an input member for recording medical information communicated by a first person to a second person during a physical examination of the designated patient, said information being recorded by said second person in the recording member in the form of predetermined encoded indicia in at least one recording section of said recording member;

a computer having a plurality of report section templates stored therein including a first report section template corresponding to a recording section for the patient's current medical condition, a second report section template corresponding to a recording section for the patient's physical examination, a third report section template corresponding to a recording section for the patient's diagnosis and a fourth report section template corresponding to a recording section for the patient's treatment plan, each of said report section templates comprising optional text variable segments each of which are assigned to a selected one of said predetermined encoded indicia, said computer being operative to decode each of said one of the predetermined encoded indicia recorded in the recording member into the assigned optional text variable segment in each applicable discrete recording section and storing the same in a retrievable memory location; and

an imaging member responsive to the computer for preparing a patient's report specific to the designated patient's at least one of medical condition, physical examination, diagnosis and

treatment plan comprising the optional text variable segments stored at retrievable memory locations.

8. The medical documentation system of Claim 7 wherein said computer is programmable to assign an optional text variable segment to each one of said predetermined encoded indicia.

9. The medical documentation system of Claim 7 wherein said computer further comprises

a comparator for comparing the optional text variable segments to the encoded indicia recorded on the recording member.

10. The medical documentation system of Claim 9 wherein said computer verifies the results of the comparison of the optional text variable segments with the encoded indicia recorded on the recording member.

11. The medical documentation system of Claim 7 wherein the recording member is a form.

12. The medical history documentation of claim 11 wherein said form includes at least one discrete reporting section for recording information relating to a general examination of the designated patient.

13. The medical history documentation of claim 11 wherein said form includes at least one discrete reporting section for recording the information relating to a gynecology examination of the designated patient.

14. The medical history documentation of claim 11 wherein said form includes at least one discrete reporting section for

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recording information relating to an ophthalmologic examination of the designated patient.

15. The medical history documentation of claim 11 wherein said form includes at least one discrete reporting section for recording information relating to an urological examination of the designated patient.

16. The medical history documentation of claim 11 wherein said form includes at least one discrete reporting section for recording information relating to an orthopedic examination of the designated patient.

17. A medical history documentation system comprising

a recording member having a plurality of discrete recording sections formed thereon, each of said discrete recording sections being programmed to record information relating to at least one of a designated patient's current medical condition, a physical examination, a diagnosis and a treatment plan;

an input member for recording medical information verbally communicated by a first person to a second person during a physical examination of the designated patient, said information being recorded on the recording member by said second in the form of predetermined encoded indicia in at least one discrete recording section of said recording member;

a transcriber for providing a plurality of report section templates including a first report section template corresponding to a discrete recording section for the patient's current medical

condition, a second report section template corresponding to a discrete recording section for the patient's physical examination, a third report section template corresponding to a discrete recording section for the patient's diagnosis and a fourth report section template corresponding to a discrete recording section for the patient's treatment plan, each of said report section templates comprising a plurality of optional text variable segments each of which are assigned to a selected one of said predetermined encoded indicia, said transcriber being operative to decode each of said one of the predetermined encoded indicia recorded on said recording member into the optional text variable segment assigned thereto for each applicable discrete recording section; and

an imaging device responsive to the transcriber for preparing a patient's report specific to the designated patient comprising a combination of selected optional text variable segments for a designated patient's at least one of medical condition, physical examination, diagnosis and treatment plan.

18. The medical history documentation system of Claim 17 wherein said transcriber further comprises

a computer which is includes a programming for the decoding of the optional text variable segments corresponding to each one of said predetermined encoded indicia.

19. The medical history documentation system of Claim 18 wherein said computer further comprises

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a comparator for comparing the optional text variable segments to the encoded indicia recorded on the recording member.

20. The medical history documentation system of Claim 19 wherein said computer verifies the results of the comparison of the optional text variable segments with the encoded indicia recorded on the recording member.

21. A method for documenting information for a designated condition comprising the steps of

conducting by a first person an examination of a designated condition in accordance with an examination procedure wherein the first person during the examination of the designated condition communicates information of the condition to be documented;

recording by a second person with a recording device in a predetermined format the information of the communicated condition communicated by the first person during the examination of the designated condition;

processing the information recorded by the recording device to produce in a programmable format a patient report containing the information of the designated condition; and

comparing the information of the designated condition on the report with the information of the condition recorded by the recording device to verify the accuracy of the information.

22. A method for documenting verified patient medical information for a patient's history file comprising the steps of

conducting by a first person a physical examination of a patient in accordance with an examination procedure wherein the first person during the physical examination of the patient communicates the patient medical information to be documented;

recording by a second person with a recording device in a predetermined format the patient medical information communicated by the first person during the physical examination of the patient;

processing the patient medical information recorded by the recording device to produce in a programmable format a patient report containing the patient medical information; and

comparing the patient medical information on the patient report with the patient medical information recorded by the recording device to verify the accuracy of the patient medical information on the patient report.

23. The method of claim 22 further comprising the step of

entering the verified patient report into a patient's history file.

24. The method of claim 22 wherein the step of comparing comprises the step of

determining if the results of the comparison shows that the accuracy of the patient medical information is verified or unverified.

25. The method of claim 24 wherein the step of comparing further comprises the step of

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if the comparison of the determining step shows that the accuracy of the patient medical information is unverified, correcting the patient medical information to make the same verified.

26. The method of claim 22 wherein the step of recording by a first person comprises the step of

writing the patient medical information on a preprinted form.

27. The method of claim 22 wherein the step of recording by a first person comprises the step of

entering the patient medical information into a computer which is capable of performing the step of processing the medical information.

28. The method of claim 22 wherein the step of processing comprises

dictating the patient medical information into a dictating system; and

transcribing the dictation to produce the patient report.

29. The method of claim 22 wherein this step of processing comprises the step of

programming the computer to process the patient medical information for producing an output signal representative of the patient report having the patient medical information.

30. The method of claim 29 wherein the step of processing further comprises

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generating in response to the output signal a display which represents the patient report.

31. The method of claim 29 wherein the step of comparing comprises

electronically comparing the patient medical information as entered into the computer with the patient medical information contained in the output signal.

32. The method of claim 29 wherein the step of processing further comprises

displaying the patient record containing the patient medical information as an image on a monitor in response to the output signal.

33. The method of claim 29 wherein the steps of processing further comprises the step of

generating a patient report in the form of a printed image having the patient medical information.

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